South Dakota Health Care Solutions Coalition

Meeting Notes 11/18/2015

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Jerilyn Church, Steve Emery, Tony Venhuizen, Dr. Mary Carpenter, Monica Huber, Terry Dosch, Sen. Bernie Hunhoff, Mike Diedrich, Rep. Don Haggar, Sen. Deb Peters, Sonia Weston, Jennifer Stalley, Rep. Spencer Hawley, Jason Dilges, Sen. Deb Soholt, Sen. Corey Brown, Sunny Colombe, Richard Huff, Gilbert Johnson, Sara DeCoteau, Kathaleen Bad Moccasin, Sen. Troy Heinert, Willie Bear Shield, Sen. Billie Sutton, Deb Fischer-Clemens, Rep. Justin Cronin, Charlene Red Thunder, Carol Diaz (IHS contracting-guest presenter)

Welcome and Introductions

The opening prayer was offered by Sen. Troy Heinert.

The meeting started with introductions.

Review of Previous Meeting Minutes

Don Novo asked the group to review the minutes SD Health Care Solutions Coalition meeting minutes 11-04-2015.pdf from the previous meeting and let Kelsey Smith (Kelsey.Smith@state.sd.us) know if there were any changes needed.

Kim Malsam-Rysdon thanked the group for their input on the State's response to the CMS white paper regarding 100% FMAP for services provided to Medicaid enrolled Native Americans. CMS requested a clarification call with South Dakota to make sure they understood the State's comments and thanked the state for the level of detail in the response. CMS reiterated their commitment to moving in the direction of expanding what services would be eligible for the 100% FMAP. The formal comment period closed yesterday (November 17) and CMS they would be working toward finalizing the policy changes as quickly as possible, but not likely by the first week of December. However, because they recognize the timeline that South Dakota is on in its discussions relating to possibly Medicaid expansion, they committed to providing guidance specific to South Dakota via a letter to Governor Daugaard.

The Great Plains Tribal Chairmen's Health Board (GPTCHB) also sent comments to CMS. Their comments were aligned with those of this Coalition, as well as offering some additional insights that should be very helpful to CMS. Senator Brown expressed his appreciation to Jerilyn Church for GPTCHB's comments on the white paper. Sonia Weston indicated that the Oglala Sioux Tribe also submitted comments to CMS on the white paper supporting the policy change and asking for changes that will directly improve tribal member's health.

Subcommittee Reports

Access to Care Subcommittee

This subcommittee met last on November 4 and reviewed proposals from providers of telehealth services, specifically e-emergency services and e-specialty consults; they also heard about a couple of IHS/Tribal prenatal care programs. Additionally, CareSpan presented information about their services

based on a pilot project on with the Yankton Sioux Tribe in Wagner which they are working with the GPTCHB.

New Services Subcommittee

This subcommittee also met on November 4. Subcommittee members provided overviews on Community Health Representative (CHR) programs at IHS and as part of the Rosebud and Oglala Tribal programs. Capt. John Schuchardt, a pharmacist at IHS, gave an overview of IHS medication therapy management (MTM). This subcommittee met again this morning (11/18) and learned about Community Health Worker (CHW) and CHR programs in other states. The group discussed the need for Community Health Worker services in South Dakota. Additionally, the group talked about opportunities for providing MTM through the Medicaid Health Homes program or through primary care providers for beneficiaries who need that support.

Behavioral Health Subcommittee

The Behavioral Health Subcommittee met for the first time on November 5. There were several presentations, including an overview of current Medicaid behavioral health services, as well as information about some specialized programs through IHS and Tribal organizations. The group talked about some of the challenges and barriers related to the current structure of behavioral health programs, and opportunities to make changes. The Health Homes model was discussed as one program that offers some distinct flexibility to expand services. Future meetings will focus on how IHS and tribal programs can provide additional behavioral health services.

IHS Contracting – Carol Diaz (for Ron Cornelius)

Carol Diaz shared a handout of the IHS contracting process (which is also available on the IHS Acquisition Process website, at http://www.ihs.gov/dap/acquisitionprocess/?mobileFormat=true). She explained how they must follow Federal Acquisition Regulations (FAR) and the IHS manual, and that their process starts with the federal appropriations to IHS and what they are allowed to purchase. She also pointed out that the Tribes under 638 programs have their own acquisition rules and do not have to follow the IHS contracting rules.

Core steps in the IHS contracting process are:

1. Need is defined.
2. Funding document required (based on federally-appropriated funds).
3. Market research, statement of work or statement of objectives, independent government estimate evaluation criteria, acquisition planning document (if applicable).
4. Competition requirement (small business review, JOTFOC - Justification for other full and open competition).
5. Request for proposal created.
6. Solicitation advertised for specified period (based on what soliciting, with a minimum of 30 days, 45 for research and development); usually includes a question and answer period with potential offerors.

7. Proposals submitted.
8. Technical review phase, source selection, negotiations.
9. The award, which may include the establishment of a contracting officer to oversee the contract.

Within IHS, contracting officers are the only officials who have the delegated authority to enter into contracts, which are legally binding and consist of: 1) an offer, 2) acceptance, 3) consideration. Solicitations over $25,000 must be advertised on FedBizOpps (https://www.fbo.gov/).

IHS contracting officers consider all aspects because they need to be fair to the public, fair to the government and fair to businesses. IHS can make awards in various ways, depending on what is needed. What often takes the most time is defining the need and/or the market research. Once something is in the actual contracting process, it is relatively fast. For any kind of new contract structure or agreement, IHS would have to look at whether it falls under the current acquisition structure; if not, they would need to go to the headquarters-level to determine what could be done outside of the normal processes. This is what they had to do for PRC contracting.

The group asked how this process would work for the kinds of services this Coalition is interested in setting up, for example, a contractual relationship with Medicaid for provider services. Richard Huff explained that it depended to a large degree on what CMS will allow to count as the service being provided "through IHS."

Kim Malsam-Rysdon explained that is where the State can help IHS. The key, based on comments South Dakota made, as well as those made by other states, was flexibility in the contractual relationships. For example, the National Association of Medicaid Directors (NAMD) was unanimous in comments about flexibility for states and IHS/Tribal entities. We should determine what would work for South Dakota wants and advocate for its approval at the federal level.

The group said ideally what they would like to see is an all-inclusive area-wide contract that would allow all Medicaid-enrolled providers to deliver services to Native Americans. IHS does have other area-wide contracts today. If the State were able to get an area-wide vehicle through IHS to allow any Medicaid providers to serve Native Americans enrolled in Medicaid, it should be as flexible as possible for how the services are delivered (e.g., in person or telehealth options).

The point was made that the Tribes, IHS, and the State need to ensure that there remains a robust IHS and Tribal system of care, and all should continue to work on expanding access to care for more Native Americans. The CMS requirement of care be received "through" and IHS or Tribal provider and IHS or Tribal provider "owning" the medical records of all Native American Medicaid beneficiaries must be addressed. There should be a broad enough vehicle to accommodate the needs related to where people get services, but also recognize that the treaty obligation is with IHS, so the solution must find a way to keep that connectivity or relationship.

Representative Justin Cronin indicated that fundamentally the issue of access to care is a treaty right and responsibility of Indian Health Services. Given that Indian Health Service is vastly underfunded and despite historical attempts to address that issue federally, the changes moving forward should support the 100% FFP follow the individual regardless of where they receive care. There are numerous reasons why IHS is unable to meet the healthcare needs for Native Americans in their service areas so this

change should at a minimum allow individuals to take the 100% federal Medicaid funding they receive and use that to access care at a provider of their choice that can meet their needs.

Kim Malsam-Rysdon requested a small group of volunteers to work on the issue of contracting and come up with some recommendations before the next Coalition meeting, December 3. This team would explicitly address issues of 1) providers, 2) service delivery mechanisms, and 3) payment structures. Volunteers included: Sonia Weston, Rep. Justin Cronin, Richard Huff, Carol Diaz, Kathaleen Bad Moccasin, Sunny Colombe, Deb Fischer-Clemens, Jerilyn Church, and Brenda Tidball-Zeltinger.

Revised Medicaid Expansion Projections

Lynne Valenti and Brenda Tidball-Zeltinger presented information about updated Medicaid expansion numbers (please refer to slides, posted at *boardsandcommissions.sd.gov* for more details).

Demographics of the Uninsured in South Dakota

Of the estimated 55,737 South Dakotans who are ages 18 – 64 and uninsured (about 8% of the population):

- Most are young (ages 19 to 34)
- The majority are male (58%)
- Six in 10 live either in the West or Southeast Region
- Most work (73%), and of those who work, most have full-time jobs
- 30% are Native American

Cost projections

During the early stages of the implementation of the Patient Protection and Affordable Care Act (ACA), South Dakota estimated the potential Medicaid expansion population as 48,564 individuals. The State assumed a 40% uptake rate for year one (based on national estimates at the time), 90% by year two, 100% by year three. Projected costs were $6,103 per enrollee, based on costs of Low Income Family adults in Medicaid already. Using these assumptions, by 2020, when the state costs for the expansion group would be 10%, the total estimated annual costs for the State were approximately $34M. In these original cost estimates, the State also did not assume the 100% FMAP rate for Native Americans in the expansion group, and administrative costs included 39 new FTE, primarily related to eligibility and claims staff.

The State recently revised the projections and increased the number of potential eligibles to 49,721 plus a 10 percent "contingency" for a total of 54,693. Additionally, costs per enrollee were updatd to $6,454, plus a 20 percent "contingency" for an expected cost of $7,744. This time, based on other states' experiences, South Dakota assumed a much higher take-up rate – 90% in year one and 100% by year two. Final projections of benefit costs will need to consider any new services that are recommended by the Coalition.

Administrative costs will depend to some degree on what kind of expansion program is implemented. The State will likely need to update the 39 FTE to support claims processing and other administrative needs.

There are two scenarios for projecting the costs of expansion in the future. One scenario assumes that none of the Native Americans in the expansion are able to access 100% FMAP services in the future, i.e. IHS/tribal program contracts don't cover all potential services in the future. That scenario leads to an annual projected cost of $45.1 million per year to the state, starting in 2020.

The second scenario for projecting costs of expansion is to assume all Native Americans in the expansion are able to access 100% FMAP services in the future, i.e., HIS/tribal program contracts cover all potential services in the future. This scenario results in an actual projected cost of $33.5 million per year to the state, starting in 2020. This is very close to the original projections.

The state will be using the most fiscally conservative estimate for the costs of Medicaid expansion to determine if expansion is financially feasible in the long term. At this point, that projection is a cost of $45.1 million per year. Any extra state funds freed up by the implementation plan but not needed for Medicaid expansion would not be spent before they are accrued, to ensure the state is able to support the long term costs of expansion.

Expenditure information for services provided to IHS eligibles outside the IHS/tribal program system were also updated. South Dakota expended $139M for Medicaid services for Native Americans in SFY15, $66.7M of which were State general fund dollars. To get to $45.1M for expansion, the State would need to save double that amount ($90.2M) by leveraging the new 100% FMAP opportunity to the maximum extent possible.

The group asked if South Dakota Medicaid looked at other states with large Native American populations and their uptake of Medicaid under expansion. Brenda Tidball-Zeltinger noted that they didn't consider that level of specificity when they researched the experiences of other states – it was a more general look at total uptake.

The group wanted to know how many Native Americans in South Dakota today are eligible for Medicaid but not enrolled, especially as the Native American population is one of the fastest growing populations in the State. A focus on getting anyone with access to IHS services, who also is eligible for Medicaid, enrolled in Medicaid could help free up IHS dollars. This will be an area of recommendation for the Coalition. The group discussed the continued need for IHS to assess how many adults today are served by IHS with incomes 138% of FPL or below (potential expansion population). Richard Huff indicated that the sites should be able to identify this. This information will enable the sites to identify the new revenue that would be available to IHS so that additional services can be provided for other priority areas. Sonia Weston asked if that information could be shared at future meetings.

Expansion Timing

The group discussed the timing of expansion and how it ties to the 100% FMAP opportunity. The expectation is that the State would start expansion in fiscal year 2017, assuming the 100% FMAP is in place before the start of SFY17 (July 1, 2016) and the plan supports the ramp-up in state costs and supports the $45.1 million projection at this point starting in 2020.

Jason Dilges explained that by 2020, Medicaid has to be able to save $45M in existing state general funds to be able to fund expansion. The recommendations of the Coalition and subcommittees would need to be put in place to achieve the needed dollars.

The process for the state to expand Medicaid is for the Medicaid budget to have the needed federal authority to be able to accommodate expansion. There would be no general funds added for expansion because the expectation is that the plan would have to be at least general fund neutral for the state to expand Mediciad.

The next step would be for the state to develop and submit a Medicaid State Plan Amendment that would need to do two things- change the eligibility categories for Medicaid to cover the new population and accommodate the other changes necessary to be able to get the 100% FMAP to fund expansion. The process to change the Medicaid state plan has to include tribal consultation, and tribes need to support the plan for the state to be able to expand Medicaid by using 100% FMAP for IHS eligibles.

Some people have asked if the state could just get the 100% FMAP and not expand Medicaid. That would not be consistent with Governor Daugaard's intent or discussions with stakeholders. That plan would also not be supported by tribes.

Once CMS provides final guidance on the changes to use 100% FMAP, the State can move relatively quickly. However, if CMS doesn't provide guidance until April or later, that postpones the expansion opportunities. CMS has acknowledged that they understand the State is under a tight timeframe and if they cannot get the final guidance out before the end of December, they have committed to giving Governor Daugaard a letter of their intent to assist the Governor in assessing whether the state can move forward.

Depending on the federal changes, there may be significant state general fund savings beyond what is needed to support the costs of expansion. The group asked if the State has a mechanism to capture the savings from each year. Jason Dilges explained that whatever the net savings is would need to be captured, perhaps in a separate savings fund; however, the State has to have enough flexibility to be able to move the dollars around to meet changing needs and services. Kim Malsam-Rysdon stressed the need to be evaluate several factors involved in the expansion projections to ensure stakeholders understand the impact of expansion. It will be critical that the amount of funds freed up by the 100% FMAP option and the actual costs of expansion be part of ongoing evaluation efforts.

The group reiterated it also is very important that IHS and the Tribes are included in the process and buy in to the plan. The Tribes need to see the benefits of doing this for their people. This is a great opportunity, and all the Tribes very much want to see services and access to services expanded for all Native Americans. Sonia Weston outlined that Oglala Sioux Tribe has discussed this and their members are going to need to clearly see how the plan would support healthcare for tribal members and have the support of their Tribal Chairman and Tribal Councils in order to move forward.

Kim Malsam-Rysdon concluded the meeting with a reminder that the Coalition would spend time at the next meeting (December 3) discussing the Subcommittee's draft recommendations up to this point. The group will also discuss approaches to expansion in other states now that there is more experience with some of those approaches. The group's meeting on December 16 will focus on finalizing its high level recommendations. A draft report will be provided to the Coalition by 12/30/15. The Coalition will meet on January 6 to finalize the report and recommendations and discuss next steps. It is anticipated that after the Coalition completes its recommendations a more detailed implementation plan will need to be developed by a small group lead by the state and the Great Plains Tribal Chairman's Health Board.

Next Steps:

- Small group to meet to develop a draft proposal for IHS contracting to best capture 100% FMAP

Next Meeting

Thursday, December 3, 1 p.m. – 3 p.m., Central Time, at the AmericInn in Fort Pierre, SD

REMINDER - All the materials from the Coalition and Subcommittees can be found on the State website at:

boardsandcommissions.sd.gov